



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PALLADIUM FOR SURGERY BROWNSVILLE
1100 N EXPRESSWAY STE 3
BROWNSVILLE TX 78521-1407

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-04-7912-01

MFDR Date Received

March 9, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am now requesting mediation for this matter. . . . I have enclosed documentation for other patient during the same time period, showing discrepancies in payment methodology utilized by Liberty Mutual"

Amount in Dispute: \$52,106.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Services provided by the entity 'The Palladium for Surgery Brownsville' are not payable under the Texas Labor Code as the billing entity does not met the criteria for a facility or a provider, per the Labor Code and the Texas Workers' Compensation Act, Section 401.011"

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 27, 2003 to August 12, 2003	Ambulatory Surgical Services	\$52,106.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on March 9, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 30, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- X003 – THE CHARGE FOR THIS PROCEDURE MATERIAL AND/OR SERVICE IS NOT NORMALLY BILLED. (X003)
 - X094 – CHARGES INCLUDED IN THE FACILITY FEE. (X094)
 - X170 – PRE-AUTHORIZATION WAS REQUIRED BUT NOT REQUESTED FOR THIS SERVICE PER TWCC RULE 134.600. (X170)
 - X815 – THIS PROCEDURE IS INCIDENTAL TO THE PRIMARY PROCEDURE AND DOES NOT WARRANT SEPARATE REIMBURSEMENT. (X815)
 - Z601 – THE CHARGE EXCEEDS USUAL AND CUSTOMARY. (Z601)
 - Z605 – THE CHARGE EXCEEDS THE SCHEDULED ALLOWANCE FOR MULTIPLE PROCEDURES. (Z605)
 - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)

Findings

1. The insurance carrier denied disputed services with reason code X170 – “PRE-AUTHORIZATION WAS REQUIRED BUT NOT REQUESTED FOR THIS SERVICE PER TWCC RULE 134.600. (X170).” Former 28 Texas Administrative Code §134.600(b)(1), effective January 1, 2003, 27 *Texas Register* 12359, provides that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury listed in subsection (h) only in an emergency or when preauthorization was approved prior to providing the health care. §134.600(h)(2) states that the non-emergency health care requiring preauthorization includes “outpatient surgical or ambulatory surgical services.” Review of the submitted information finds no documentation to support that the disputed services were preauthorized. No documentation was found to support that the services were provided as the result of an emergency. This denial reason is supported.
2. The respondent’s position statement asserts that “Services provided by the entity ‘The Palladium for Surgery Brownsville’ are not payable under the Texas Labor Code as the billing entity does not met the criteria for a facility or a provider, per the Labor Code and the Texas Workers’ Compensation Act, Section 401.011.” Per 28 Texas Administrative Code §133.307(j)(2) effective January 1, 2003, 27 *Texas Register* 12282, “The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of a request. Any new denial reasons or defenses raised shall not be considered in the review.” Review of the explanations of benefits finds no documentation to support that the above denial reason was presented to the requestor prior to the date the request for medical dispute resolution was filed. The Division concludes that the respondent has not met the requirements of §133.307(j)(2), and may not now raise such new defenses. Consequently, any new denial reasons or defenses raised in the respondent’s position statement shall not be considered in this review.
3. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Former 28 Texas Administrative Code §133.307(e)(2)(A), effective January 1, 2003, 27 *Texas Register* 12282, requires that the request shall include “a copy of all medical bill(s) as originally submitted to the carrier for reconsideration.” Review of the submitted documentation finds that the request does not include a copy of the medical bill(s) as submitted to the carrier for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(A).
6. Former 28 Texas Administrative Code §133.307(e)(2)(B), effective January 1, 2003, 27 *Texas Register* 12282, requires that the request shall include “a copy of each explanation of benefits (EOB) . . . relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB.” Review of the submitted documentation finds that the request does not include a copy of all pertinent EOBs detailing both the carrier response to each initial bill and the carrier response to each request for reconsideration. Neither has the requestor submitted convincing evidence of carrier receipt of the provider request for the missing explanations. The Division concludes that the requestor has not met the requirements of §133.307(e)(2)(B).

7. Former 28 Texas Administrative Code §133.307(g)(3)(A), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send “documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier’s receipt of that request.” Review of the submitted information finds that the requestor has not provided documentation of the request for and response to reconsideration or convincing evidence of the carrier’s receipt of that request. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(A).
8. Former 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the requestor’s documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
9. Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
 - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline*, that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors” (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they “allow the hospitals to affect their reimbursement by inflating their charges” (22 *Texas Register* 6268-6269). Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. Review of the redacted documentation finds that the requestor did not discuss or explain how the sample EOBs support the requestor’s position that additional payment is due. The insurance carriers’ reimbursement methodologies are not described on the EOBs. The requestor did not explain or discuss the sample carriers’ methodologies or how the payment amount was determined for each sample EOB. Nor did the requestor discuss or demonstrate whether such payment was typical for such services or for the services in dispute.
 - The requestor did not support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____ Signature	<u>Grayson Richardson</u> Medical Fee Dispute Resolution Officer	<u>July 19, 2013</u> Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.